# ILLINOIS DEPARTMENT OF PUBLIC AID

## Illinois Medical Assistance Program

## Provider Enrollment Application

**(Must be Typed)**

**All fields must be completed or the application may be returned. If a field is Non-Applicable, the applicant should type N/A.**

**SECTION A: PROVIDER:**

1. New Enrollment ☐ Re-Enrollment ☐ Name Change ☐ Reinstatement Request ☐ 2. Provider Type

3. Provider Name

4. Primary Office Address Street

5. City 6. County

7. State 8. Zip 9. Telephone # ( ) - 10. Fax ( ) -

11. Email Address (3)

12. SSN 13.FEIN 14. IBT# 15. License/Certification #

16. DEA# 17. Natl Prov ID# 18. Medicare Part A# 19.Organization Type

20. Control of Facility 21. Fiscal Yr. 22. CLIA #

**SECTION B: SERVICE/SPECIALTY:**

23. Category of Service(s) / / / / / / / / / / /

24. Provider Specialty: Primary Specialty Secondary Specialties / / / / /

25. Physician UPIN No. 26. OBRA Qualification (Physicians Only) / / / /

27. Hospital Admitting Privileges (Physicians Only)

Hospital Name Address

Hospital Name Address

28. Pharmacy Location 29. Pharmacist In-Charge 30. License #

31. Electronic Billing? Yes ☐ No ☐ 32. If Yes, Pharmacy Software Vendor Name 33.Pharmacy NCDCP#

34.Transportation: Taxi Base/ Meter/Flag Rate 35.Taxi Mileage Rate 36. Medicar: Hydraulic Manual Lift or Ramp Yes ☐ No ☐

37. Long Term Care Medicare Bed Capacity 38. Long Term Care Medicare Fiscal Intermediary

39. Long Term Care Building ID Code

**SECTION C: FORMER PARTICIPATION:**

40. Change of Ownership Yes [ ] No [ ] Effective Date [ ]

41. Former Provider Number [ ] Former Provider Name [ ]

**SECTION D: ADDITIONAL PARTICIPATION**

42. Provider Type [ ] 43. Provider Number [ ]

44. Provider Name [ ]

**SECTION E: PAYEE INFORMATION:**

45. Name [ ] 46. Telephone# ( ) -

47. D/B/A [ ]

48. Street Address [ ]

49. City [ ] 50. State [ ] 51. Zip [ ]

52. SSN/FEIN [ ] 53. TIN Type Code [ ]

54. Medicare Part B#: [ ] 55. PIN [ ] 56. DMERC # [ ]

Name: [ ] Telephone # ( ) -

D/B/A: [ ]

Street Address: [ ]

City [ ] State [ ] Zip [ ]

SSN/FEIN [ ] TIN Type Code [ ]

Medicare Part B #: [ ] PIN [ ] DMERC # [ ]

**SECTION F: CERTIFICATION/SIGNATURE:**

I understand that knowingly falsifying or willfully withholding information may be cause for termination of participation in the Medical Assistance Program.

Under penalties of perjury, I hereby certify that all of the information provided in this application process is true, correct and complete and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the enrolling provider's employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason. I authorize the Department of Public Aid to verify the information provided on this application with other state and federal agencies.

Check this box if you want a provider handbook [ ]

Signature: [ ] Date: [ ]

Printed name of person signing above: [ ]